(Mr. STRICKLAND addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

EXCHANGE OF SPECIAL ORDER TIME

Ms. KAPTUR. Mr. Speaker, I ask unanimous consent to claim the time of the gentleman from Ohio (Mr. STRICKLAND).

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Ohio?

There was no objection.

WAR IN IRAQ AND ASSOCIATED TRAGEDIES NOT OVER

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Ohio (Ms. KAPTUR) is recognized for 5 minutes.

Ms. KAPTUR. Mr. Speaker, if the American people needed evidence that the war in Iraq and its associated tragedies are not over, it arrived in a front page picture Saturday that was carried across our country. In my hometown paper, the Toledo Blade, but also the Chicago Tribune, the Boston Globe, the Washington Post, and the New York Times.

This is the photo, First Class Sergeant Bryan Pacholski comforting David Borell, career Army guard, both from Toledo, at a military base in Balad, Iraq. The Associated Press photograph caught an emotional moment, a Toledo career soldier being consoled in his grief by a buddy after military doctors allegedly refused to treat three Iraqi children with painfully serious burns from some sort of explosive device. The soldier, Sergeant David Borell, of our 323rd Military Police Company, later wrote home an e-mail with his personal thoughts on the incident, specifically that the children had been unjustifiably denied medical treatment.

The Blade printed the story and a request on my part of our Secretary of Defense for a full investigation and a meeting with him in order to discuss how to prevent this type of situation in the future. Such an investigation is warranted because the incident, if true, flies in the face of numerous stories from the war zone telling of humanitarian acts by U.S. troops under hostile circumstances. We know our troops want to do the right thing.

Mr. Speaker, is it really U.S. policy to refuse treatment of Iraqi civilians with serious but nonlife-threatening injuries? Who made that decision? Who were the doctors involved, and why did they handle the situation as they did? Were the kids callously refused care, or was the sergeant simply overcome by witnessing their great pain? These are some of the questions that deserve straightforward answers.

The Blade, in its editorial, goes on to write, ''Given frequent news reports about the destruction of Iraq's hospitals and emergency services, of which we are all aware, and the 10-year embargo preceding the war that caused all of their hospitals to lack medical equipment and supplies, it is difficult to give much credence to a spokesman for the U.S. Central Command who contended that Iraq now has a better health care system than before the U.S. occupation. It is entirely believable that in the words of the same spokesman, U.S. forces in Iraq 'are providing health care to Iraqis, but we do not have the infrastructure to support the entire Iraqi civilian population.' ''

□ 1830

So whose fault is that? And what do we do? What do we do to build friends, more friends than enemies inside Iraq?

Most Americans probably would say that defenseless children should be taken care of in any circumstance. They, after all, did not cause the war. There are plenty of adults around to blame for that. Secretary of Defense Rumsfeld has agreed that we will begin with a meeting with Under Secretary of Defense Chu, who is in charge of personnel and deployments. Hopefully, that first meeting will begin tomorrow. My proposal will be the same, that we move some of the funds we have already appropriated because we thought the war would last longer with the siege of Baghdad, divert some of those funds to move some of our temporary field hospitals in different places in Iraq, and to put medical supplies there to treat this type of injury that Sergeant Borell saw, children who are burned, people who are bleeding, civilians who we want to be our friends.

We now hold the ground in Iraq. The question is, in the future, will we win the hearts and minds of the people? There is no greater way to do that than one by one ministering to their tragic health needs. That time is long overdue. And so I welcome the opportunity to discuss this with Under Secretary Chu, with Secretary of Defense Rumsfeld, and to make sure that no other soldier in service to this country will have to experience what Sergeant Borell experienced with no alternative given to him.

There were no kits, no medical kits that were available to the platoon other than their own small emergency kits, because they are military police. There were not hospitals in the area where these people could be referred that had decent medical supplies and backup. And so he was forced as an American to turn the family away. How do you think America is perceived by those civilians? I think they are beginning to wonder, at least that family, will America really make a difference? Yes, America really can make a difference, just give us a chance. I would welcome the opportunity as one Member of Congress to mobilize my community to provide the supplies for that first field hospital right near where Sergeant Borell and Sergeant Pacholski are serving. These are part of our flesh and blood from our community. We want to give them all the support we can. I know the Secretary of Defense will find a way to help us.

The SPEAKER pro tempore (Mr. FRANKS of Arizona). Under a previous order of the House, the gentlewoman from Ohio (Mrs. JONES) is recognized for 5 minutes.

(Mrs. JONES of Ohio addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

PRESCRIPTION DRUGS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 2003, the gentleman from Illinois (Mr. EMANUEL) is recognized for 60 minutes as the designee of the minority leader.

GENERAL LEAVE

Mr. EMANUEL. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and to include therein extraneous material on the subject of my Special Order today.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

Mr. EMANUEL. Mr. Speaker, currently both the House and the Senate are in intense deliberations to forge a compromise on a prescription drug benefit for Medicare and Medicare recipients. I am glad to see that both Republicans and Democrats after all this time are working together to try to correct this critical deficiency in the Medicare program.

When Medicare started in the early 60s, about 10 percent of the health care costs for a senior was dedicated to out-of-pocket drug costs. Today that is around 60 percent of their health care costs, or health care dollar. And so if we are going to have a health care plan for seniors and if Medicare is going to live up to its obligations that it was originally designed to do, Medicare must have a prescription drug plan.

We all know that one of the most contentious issues in the prescription drug debate is the question of how much of the cost of drugs should be paid by government and how much should be passed on to seniors. But the crux of this problem is that both the U.S. Government and American seniors are paying too much for prescription drugs. Providing a prescription drug benefit through Medicare is unfortunately only the tip of the iceberg in addressing a widespread prescription drug access issue facing our Nation.

Much more central to the inability of many seniors and other Americans to afford the prescription drugs they need is the fact that prescription drug prices are 30 to 300 percent higher than those in other industrialized nations. The truth is one of the big problems we have here in the country is that we do not have a free market as it relates to prescription drugs and drug costs. I

really believe that one of the central points of this debate is that we need a free market.

The three things I am going to discuss today are, A, the issue that American consumers, be they elderly or others, are denied access to prescription drugs from all over the world and they are a captive market, unable to buy drugs, be they in Canada, Mexico, Germany, France, where the same drugs are much cheaper than they are here in the United States. If our consumers were allowed to have access to those drugs, there would be competition and prices would drop. But because the free market is prohibited from exercising its magic, drug costs are artificially raised.

The second point I want to discuss is the American taxpayer through two different venues provides direct and indirect assistance to the drug companies to develop the drugs. Drug companies reap all the profits, and the American taxpayers do not get any of the benefits back as an investor. If we were an investor, and I come from the private sector, private sector investors when they invest in a drug, they usually look for what is called a 30 percent IR, investment return on equity. Yet the taxpayer who provides through taxes both direct assistance to the FDA as well as through the tax write-off that pharmaceutical companies get, they do not reap any of the benefits from these drugs being developed. Yet we develop these drugs, taxpayers spend billions and billions of dollars helping develop these drugs, yet the only benefit they get besides taking the drug is they pay the highest premium price out there.

I believe the right way to get the prices under control is for the investor, known as the American taxpayer, to reap the benefits of their investment dollars. And, third, deal with the area of generics and generic markets. If we allowed generics to get to market quicker, it would also create that type of competition. I think one of the problems we have here is that the American elderly, the American taxpayer and consumer have an artificial market that is in three areas, generics, taxes and access to the same drugs in other markets around the world. Because we are a captive market, we pay artificially high prices; and the American seniors specifically are the profit margin or, as I like to call them, the guinea pig profit margin for the pharmaceutical companies. I want the free market to work. The pharmaceutical companies are treating this market as a captive market. If we had a free market, we would have reduced prices.

Medicare drug benefits being considered by Congress are very expensive. Many seniors, especially those who do not have secondary insurance, will continue to have significant out-of-pocket drug costs even with the passage of a Medicare drug benefit. In addition, the high cost of drugs remains a crisis for 42 million uninsured and countless underinsured who must pay all or most of their drug costs out of pocket. Addressing the cost of prescription drugs will both make a Medicare drug benefit less expensive for the government and greatly increase the value of what is provided for our elderly. It will also make it much more likely that millions of uninsured and underinsured in this country can afford lifesaving, life-preserving prescription drugs, what their compatriots in Germany, France, England and other industrialized nations get. Prescription drug companies are a business, and they need to earn profits in order to stay in business. But as they have the right and purpose like other businesses to earn a profit, they also have a responsibility to be a good corporate citizen and abide by the same standards as other businesses.

As I said, I have worked in the private sector. I know that any private company when investing in research and development and in another company usually looks for a 30 percent return on their equity. The United States Government invests in pharmaceutical research by providing significant tax benefits for research and development expenses and American citizens subsidize the research as drug companies recoup their margins in America because of price controls in other countries. The American Government and the American people are getting no return on their investment. The pharmaceutical companies are reaping the financial benefits of the U.S. investments in their R&D without any responsibility to pass these benefits on to the government and American taxpayers.

American consumers are bearing the burden of price controls in other countries. When 50 tablets of Synthroid cost $4 in Munich and $21.95 in the United States, the most vulnerable Americans suffer. Also it is one of the great reasons that we have inflation running at close to triple or quadruple here in health care in the United States as opposed to the market as a whole. We are using individuals as the profit guinea pigs for pharmaceutical companies.

The legislation introduced by my good friend and colleague, the gentleman from Minnesota (Mr. GUTKNECHT), last week takes important steps to address the shocking disparities in prescription drug prices between the U.S. and other industrialized nations. It puts essential safety precautions in place to ensure that by opening our markets, we do not expose Americans to the dangers of counterfeit drugs. When defending the high cost of prescription drugs in this country, people will often say that the U.S. has the best health care system in the world. People come here from overseas to get a better product. But we clearly have nothing close to the best prescription drug delivery system, as many individuals are now shopping overseas for their prescription drugs. If we are going to defend our status as the best place to get health care in the world, we need to make the pillar of many people's health care, prescription drugs, accessible and affordable.

I yield to my good friend, the gentleman from Minnesota (Mr. GUTKNECHT).

Mr. GUTKNECHT. I would like to thank the gentleman from Illinois for taking a leadership role on this important issue. This is a huge issue. Members need to know that the estimate that the Congressional Budget Office is currently using is that seniors alone over the next 10 years will spend $1.8 trillion on prescription drugs. As the gentleman alluded to, I have been doing research. I should not say I have been doing research; there have been groups who have been sending me research for the last 4 or 5 years in terms of these great disparities between what Americans pay for name-brand prescription drugs versus the rest of the world. We have heard a lot about Canada; we have heard a lot about Mexico. But what has intrigued me the most is the differences between what we pay in the United States and what they pay in the European Union.

What I have here is a chart of about 12 or 13 of the largest-selling prescription drugs. This chart is old and the numbers have changed, but the percentages remain the same. This information is confirmed by research that I have done, that others have done, several groups have done this; but let me just run through a few of these examples. Augmentin, sold in the United States for an average of $55.50. You can buy it in Europe for $8.75. I have examples of these drugs. We actually went to Germany and bought some of these drugs. This is Augmentin. This is Cipro. Cipro is made by the German company Bayer. They also make aspirin. As you can see, it is a very effective antibiotic and especially in the days when we had anthrax here in the Federal buildings, we bought an awful lot of Cipro. In the United States it sells for an average of $87.99. In Europe you could buy that same package of drugs for $40.75 American. Claritin, $89. It is $18 there. Coumadin, this is a drug that my father takes. He is 85 years old. It is a blood thinner, a very effective drug. Coumadin in the United States at that time was selling for about $64.88. In Europe you can buy it for $15.80.

And the list goes on, but let me give an example, and the gentleman from Illinois, I think, made a great point about the amount that American taxpayers spend to develop these drugs. This is a drug that really chaps my hide. This is a drug, Tamoxifen. In many respects, this is a miracle drug. It is probably the most effective drug against women's breast cancer that has ever been invented. This drug we bought at the Munich airport pharmacy for $59.05. We checked here in the United States. This same package of 100 tablets of Tamoxifen in the United States sells for $360; $60 in Germany, $360 here.

As I say, the evidence is overwhelming that most of the research,

and I have a report if any of the Members would like a copy, this is a Senate report done in May of 2000, and in the Senate report, if I could just read into the RECORD, the National Cancer Institute, part of the NIH, has sponsored 140 clinical trials of Tamoxifen. It also participated in preclinical trials consisting of both in vitro, laboratory and live-subject tests. In other words, here in a Senate report we have confirmed that the taxpayers paid for much of the testing that was done on this drug.

He also referred to the drug Taxol. There was a story just a couple of weeks ago in The Washington Post. Let me just quote some of these numbers about what the taxpayers paid to develop this drug and what the pharmaceutical company got out of it.

Bristol-Myers-Squibb earned $9 billion from Taxol, which has been used to treat over a million cancer patients; but the National Institutes of Health received only $35 million in royalties. You go down the article a little bit further and it says, the GAO, the investigative arm of Congress, said that the NIH spent $484 million on research on Taxol through the year 2002. So the taxpayers invested $484 million, took it most of the way through the research pipeline, and we got $35 million back.

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Mr. EMANUEL. Let me ask the gentleman a question. Can you repeat again for those who are watching, as you note, this is a miracle drug and all the investment the U.S. taxpayers did, repeat again so everybody knows the difference between the price overseas versus the United States for those two drugs.

Mr. GUTKNECHT. Unfortunately, on Taxol I do not have that comparison. I do not think it is on my list, but the comparison is essentially the same. It is about three times more, or at least it was when it came off patent in the United States; it was more than three times more in the United States than they paid in Europe, and the American taxpayers paid for most of the R&D costs. By the GAO's own estimate, the taxpayers spent at least $484 million developing the drug, and I yield to my friend.

Mr. EMANUEL. Mr. Speaker, I ask my good friend, I did not mean to interrupt him. Did he want to keep going?

Mr. GUTKNECHT. No. I have plenty of information, but the interesting thing about these charts and these comparisons, if people doubt what they paid for these drugs, we have the receipts. So we can literally go through and say, yes, this is what we paid for Tamoxifen, $59.05 in Germany, and we did not have a special discount card. We are not German citizens; so we were not going in for socialized medicine. These are drugs that we just bought off the shelf or from the pharmacist at the Munich airport. So it is not as if they are being subsidized by the German Government. The truth is they are being subsidized by us, and what I have always said is that Americans should be prepared and we are prepared and willing. I think most Americans are willing to subsidize the research for these miracle drugs. In fact, I think we are willing to subsidize people in developing countries like Sub-Saharan Africa, but we should not have to subsidize the starving Swiss.

And finally, let me just make one last point, and I will yield back. I am with the gentleman. I happen to be a Republican. The gentleman is a Democrat, but we are both capitalists. We both understand that there is nothing wrong with the word ''profit,'' but there is something wrong with the word ''profiteer,'' and there is growing evidence now that the big pharmaceutical companies are actually spending more on marketing and advertising than they are on basic research.

Mr. EMANUEL. Mr. Speaker, I thank the gentleman. What I would like to do is I am going to turn to the gentleman from Illinois (Mr. DAVIS), our good friend and my colleague from Illinois, in a second. I would like to repeat just one point on this. If you take this market on either cancer or AIDS drugs, just those segments or families of drugs, there is not a single cancer drug today or AIDS drug on the market that was not directly developed with assistance from the United States Government, NIH; and it was not directly developed with the tax dollars from the taxpayer; and yet the only benefit of those drugs, obviously besides using them and saving lives, the American consumer, be they the elderly or just families and children, they pay, as the gentleman noted, three times more than do people in Germany, France, and other major industrialized countries; and yet we were the ones who developed it.

We were the ones who gave the tax dollars to develop this. We also not only gave it from the NIH direct funding, using tax dollars to fund it, but on the back end these companies write off their R&D. So we have to make up that loss in the tax revenue pool so they can develop these drugs; and as I think the gentleman noted in his statistics, we then get a minuscule amount of return. Actually in the private sector money like that is called dumb money. That is how they refer to it. It is foolish money. It is called dumb money. It is people who put up dumb money, do not look for the 30 to 20 percent IR on equity, and that is what has been going on for years here in this country, and we are paying premium prices; and in these companies they figure that in Germany they are going to pay X, in Canada they are going to pay Y for the same drug, England is going to pay, and they have got to make up their margin. Whom are they making up the margin with? Our neighbors, our friends, our family members; and we funded this research, and we developed these drugs.

My view is I would love for the free market to come to the pharmaceutical industry. It just has not. It is a protected industry by the United States Government, from the Tax Code to importation to the development of generics.

Mr. GUTKNECHT. Mr. Speaker, if the gentleman would yield.

Mr. EMANUEL. Yes.

Mr. GUTKNECHT. I think he used the word earlier and I think it is the critical word. He said that we are a captive market, and if we look around the world, whether it is beef and Japan or blue jeans in the former Soviet Union, anytime there is a captive market, what will happen is they will create an artificial price barrier which will guarantee that the consumers will pay outrageously higher prices, and that is what has happened here in the United States. The German pharmacist has the right to go anywhere within the European Union and buy this Tamoxifen where he can get it the cheapest for his consumers. That is part of the reason that Tamoxifen is $60 in Germany and $360 here in the United States. In fact, the companies are protected by our own FDA from any real competitive pressures which would help to keep prices down. And I do not say shame on the pharmaceutical industry; I say shame on us. They are only exploiting a market opportunity which our government has given them.

Let me just share with the gentleman and other Members from a book called ''The Big Fix'' because I think it helps tell the whole story by Katharine Greider, and she quotes a study that was done in 1998 by the Boston Globe, and they looked at the 35 highest-selling prescription drugs in the United States; and they claim, the Boston Globe, and then is repeated in the book ''The Big Fix,'' that 32 of the 35 largest-selling drugs in the United States a few years ago were actually brought through the research and development chain by the taxpayers through the NIH, the NSF, the Defense Department, or other Federal agencies, principally the NIH. So it is not shame on them, but it is shame on us. We do not get a rate of return. We get nothing except for millions of our consumers the highest prices in the world, and it is time for us to change that.

Mr. EMANUEL. I thank the gentleman. If he could yield, I would like to now ask the gentleman from Illinois (Mr. DAVIS), my good friend, who has joined us here to also speak about his district in Chicago that borders mine, but also about this issue as it relates to the pharmaceutical industry and prescription drugs and what is going on.

Mr. DAVIS of Illinois. Mr. Speaker, I thank the gentleman from Chicago (Mr. EMANUEL), my neighbor and friend, for organizing this Special Order and certainly for giving me an opportunity to participate. Our districts abut each other; and as a matter of fact, I guess before now some of what is my district was his district.

Maybe some of what was his district is my district. So we have many similarities and certainly represent some of the same people and some of the same thoughts. It is no secret that I am a supporter of the notion of reimportation of prescription drugs. As a matter of fact, I am a proud cosponsor of H.R. 847 introduced by the gentleman from Vermont (Mr. SANDERS), my good friend.

Some people might ask me why do I support the concept of reimportation of prescription drugs, and I generally say to them it is no real big deal if they understand as I do, but I do it for a lot of reasons. One, the increasing use of prescription drugs has revolutionized health care. As a result, spending on prescription drugs has increased at a rate of 12 to 13 percent a year for the past decade and will continue to increase in cost at that rate for the foreseeable future. Prescription drugs are the fastest-growing portion of State health care budgets, and many States are facing serious budget crises relative to being able to come up with enough money to actually operate. Yet millions of seniors, perhaps tens of millions, are skipping doses of their prescribed medication or splitting pills or facing a choice between food on the table or taking their prescription drugs. I know this because of the statistics. I know it because of the recent studies. I know this because every weekend when I go home, I hear about this dilemma from one or more seniors in my district.

Meanwhile, the pharmaceutical industry remains the most profitable sector of the U.S. economy with profit-to-revenue ratios of over 18 percent. I heard the gentlemen discussing profits and being capitalists and living in a capitalistic environment; and like them, I do not have a problem with profits, but I do have a problem with overcharging our seniors. So when I learn that Glucophage for diabetics is 74 percent cheaper in Canada than in the United States, I have a problem with that. When I learn that Tamoxifen for treatment of breast cancer is 80 percent cheaper in Canada than in the United States, I have a problem with that. Time does not permit, but I could easily go on and on with the list of prescription drugs available outside the U.S. at a fraction of the cost to my constituents, and when I learn that almost 80 percent of the ingredients of prescription drugs are imported, that redoubles the problem I have with the cost of prescription drugs in the United States. And when I learn that these prescription drugs are developed with millions upon millions of dollars of Federal tax money, I have a serious problem with the cost of prescription drugs in the United States.

I know that reimportation is not the sole or even most important element in providing affordable prescription drugs for our people. I for one will not rest until we have real and effective prescription drug coverage preferably as part of a system of universal health care. But absent a comprehensive solution, there is no excuse in denying Americans the same access to prescription drugs enjoyed by our Canadian neighbors.

Mr. Speaker, the prescription drug industry is sick, and that sickness is endangering the health of all America. Reimportation would be a good first dose of castor oil to bring the industry back to a more regular and healthy state. So I want to thank my colleague and neighbor from Chicago again for organizing this complex discussion on the issue of prescription drugs and how we can get the costs down, and I yield back to him and thank him so much for the opportunity to participate.

Mr. EMANUEL. Mr. Speaker, I thank the gentleman. He brought up the breast cancer; was that correct?

Mr. DAVIS of Illinois. Yes.

Mr. EMANUEL. I think it illustrates again what our good friend from Minnesota said and has brought forth examples is that, in fact, there is not a drug today, and we can also expand this to medical choice, but no drug today that is not being developed and has not been developed that is around the country that any way you look around the world in the major industrialized countries where we have trading companies, and the gentleman noted wheat, meat, steel, cars, computers, all types of products where there is ''free trade,'' and yet here in this specific area, we are paying top price, high-premium dollar. I think again, whether it is diabetes, breast cancer, there are other drugs that are on the market that affect other types of illnesses, and I think the gentleman highlights a very important point, especially given his district and my district that abut each other, how this creates inflation, and besides the uninsured, the cost of pharmaceutical drugs is the single largest cause for health care inflation in the health care industry which has been running at 20 to 30 percent of inflation.

So he brings up, I think, a very good point, and I think it is relevant to the discussion we are having today. What I am most impressed with is the bipartisanship we have here in discussing this. And I think the truth is, and I would love to hear both their thoughts on this, that while we are doing a drug prescription benefit and we are talking about it in the Senate and we are going to be taking it up here in the House, without some type of ability to have competition in that process, we are really going to be offering a benefit at top dollar, and I think, as American taxpayers are going to be paying for the prescription drug benefit that we are going to add to Medicare, we should give them a sense of competition in the market so that we can find that drug cheaper in Canada, we can find that drug cheaper in Mexico or Germany, France, or England. We want to bring that so we can squeeze the most coverage out of our prescription drug plan for Medicare.

Mr. DAVIS of Illinois. Absolutely. And one does not have to be on Medicare or Medicaid to feel the bite.

Mr. EMANUEL. Right. I thank the gentleman. I yield to the gentleman from Illinois (Mr. KIRK).

Mr. KIRK. Mr. Speaker, I would like to compliment the gentleman from Illinois, my neighboring colleague from Chicago, because I know not only is he leading on this issue, but he is leading on creating a proposal that fits within our budget. And there is a very important point here, that we are going to make a promise to America's seniors and they are going to count on that promise. So that promise has to be sustainable and affordable. By crafting a proposal which fits within the budget resolution, my colleague from the other side of the aisle is crafting a serious proposal and is joining in the debate in a particularly productive way, and I want to compliment him on that.

Mr. EMANUEL. I appreciate that. I yield again to the gentleman from Minnesota if he had some additional comments because I have some other things, but I would like him to go ahead.

Mr. GUTKNECHT. Mr. Speaker, let me just talk about a couple of things, and I think as we talk about this new benefit, and I think we all recognize there are far too many seniors that are not getting the prescription drugs that they need, there was a study done several years ago by the Kaiser Foundation, and they found in their survey that 29 percent of seniors responded that they have had prescriptions which they did not have filled because they could not afford them, 29 percent.

Mr. EMANUEL. So that is about one third.

Mr. GUTKNECHT. About one third. And I say shame on us because we have the power to do something about that.

□ 1900

I spoke several weeks ago to the Community Pharmacists, and I just had received this report from the Kaiser Foundation. I asked them as I looked out over this audience of roughly 300 pharmacists from all over the United States, ''Has this ever happened to you, where seniors come into the pharmacy, they hand you a prescription and you tell them how much it is going to be, and they drop their head and they say, 'well, I will be back tomorrow,' and they never come back?''

Shame on us. Shame on us. We need to do something about that.

But as has been mentioned by several of my colleagues, if we go about this in the wrong way, we may not do enough to really help those seniors who really need the help. But, worse than that, we may bankrupt our children, and there is something wrong with that.

Let me also mention that we are moving ahead with this, and we have heard some of the sponsors of the various bills say, oh, but we will have these groups, and get very significant discounts and really good deals on prescription drugs.

Well, this is a study recently done by one of the cardinals of the Committee on Appropriations, and they literally went through and found out how much the Federal Employees Benefit Program is paying for some of these drugs. It is rather eye-opening.

There are some areas where they are actually getting good discounts and are competitive with the prices they get in Europe. But let me give you some examples. The Blue Cross-Blue Shield plan, for example, on Coumadin mentioned earlier, even with their discount, the combination of what the Blue Cross-Blue Shield plan cost is, and you add in the beneficiary cost, the total cost for Coumadin under the Blue Cross Blue Shield plan for a Federal employee is $73.74. Now, Coumadin can be bought for $15.80 in Europe. So $73, that is the Federal plan. You read down the list of all kinds of other drugs. It is very similar.

Zocor, the total cost for Zocor under the Federal plan, Zocor is one area where it actually is cheaper, but not much cheaper. With their deep discount, the total cost is $17.48. That same drug in Europe would be $28.

But as you go through the list, what you find is in virtually every category, even with these ''deep discounts'' that the Federal employees' plan is able to get, it still is significantly more than the average consumer gets them for in Europe.

One final point, if I could, the argument that many people make against reimportation is safety. But what about safety?

Mr. EMANUEL. That is a very important point.

Mr. GUTKNECHT. We import every day thousands of tons of food. It surprises me how many tons. In fact, the number I remember is we import roughly 318,000 tons of plantains every year, and every time we eat a plantain that comes in from a foreign country, we take a certain amount of risk, because that could contain some foodborne pathogen.

We keep very good records on how many people get ill from eating imported foods. Let me give a couple of examples. In 1996, 1,466 Americans became seriously ill eating raspberries from Guatemala, 1,466. The next year they did a little better. Only 1,012 Americans became seriously ill from eating raspberries from Guatemala.

The point I am really trying to make here is we take a certain amount of risk. I believe that the risk, particularly with the new technologies, and I am holding in my hand a tamper-proof, counterfeit-proof package for pharmaceuticals.

Here is one that is currently in use by the company Astrozenica. This is the first version of the tamper-proof, counterfeit-proof packaging. So this whole issue of safety relatively speaking, even today, it is very, very safe.

But with the new technology that is going to be coming on line, I am holding in my hands, and you cannot see this, but a little vial, and inside this vial there are 150 microcomputer chips. They are so small you can barely see them with the naked eye. But this literally is the next version of the UPC code.

Within 2 years they will be embedding these chips into packaging, so that we absolutely can know that this package of drugs was produced at the Bayer plant in Munich, Germany, on September 8 of this year, and was shipped to so and so.

So the whole idea that we cannot do this safely, it seems to me, is a specious and almost goofy argument. So I do not think we should even engage in it. It can be done, it is being done. It is far more safe to import drugs than it is raspberries from Guatemala.

Mr. EMANUEL. The only reason I had a smile cross my face is when you said the word ''embedding,'' I said who knew the Pentagon was going to be so far ahead of the pharmaceutical industry, and now they are going to copy from them.

But the truth is, we all were exposed in the '80s and '90s to the notion of the $500 hammer, where the Pentagon was off buying $500 hammers, when if you just went down to the hardware store you could go down there.

The fact is, your chart up there shows exactly the similarity that is happening now to the American taxpayer and consumers, where you could buy these same drugs overseas in different markets for far cheaper than we are buying them here, and it is the equivalent.

And why is that? Just like the $500 hammer, the fix is in. So if you go down the specific area, and I do not blame the pharmaceutical industry, they are playing the game just like they are supposed to play it, and they are rigging the game and system just like they are supposed to, for maximum profit.

But take it, whether it is in the generic drug laws or in our patent laws, they are keeping generic drugs off the market, therefore driving up the cost of name brand drugs, making it more expensive for all of us. If generic drugs were on the market and the system was not being fixed, you would have real competition.

What has happened is, the Wall Street Journal did a story the other day, as generics have started to come to market quicker and there has been a quicker process set in place by the FDA to approve generics, we have allowed that patent not to be gamed for an additional 30 months, we have, in fact, seen prices drop.

They have, in relation to the importation issue, pharmaceutical industries in that area have gamed the system very well, prohibiting us from buying the same type of drugs in either Germany, Canada, France, England, Italy, Israel, wherever, they have gamed the system. We are not prohibited from buying computers, cars, food items, other types of items. We are prohibited in this space.

What is the impact? Those same drugs, cheaper over there; more expensive here at home. Yet they are the same drugs we paid for the development.

Then through the Tax Code, the IRS, where we do an R&D tax write-off, where they are allowed and subsidized by the taxpayers for the research and development, yet they get a direct subsidy from the NIH.

I highlighted the area through the NIH of cancer drugs and AIDS drugs. Not a single drug in either one of those families has been developed without direct assistance by the government, yet, again, in that area we are paying prime dollar versus our brethren in the other industrialized nations.

So I actually take my hat off to the pharmaceutical industry, because they have worked the system to their benefit. Now, my hope is, if you go back in history and look at this in fact, when Medicare and Medicaid was first developed and voted on, it received overwhelming bipartisan support. Now, these are early preliminary stories in fact.

We are seeing right now that in the Senate, as they debate the prescription drug benefit for Medicare, we are seeing the early stages of bipartisanship, and we can discuss, argue, amend about the right approach. My hope is that when we have a chance here in the House, that that same bipartisanship would be approached with regard to the prescription drug bill, but that bill would include something on generics.

Over there they have a bill. Here, the gentleman from Ohio (Mr. BROWN) has a bipartisan bill dealing with generic reform, dealing with the update of the patent laws as it relates to what the gentleman from California (Mr. WAXMAN) developed and passed in 1984 and Senator HATCH. I would hope that we would update our laws in the generic area. I would hope we could update our laws as they relate to importation.

And we have a bipartisan bill, the gentleman and I have. We have a generic bipartisan bill here. So we would keep that spirit and that tradition as it relates to Medicare, as it relates to prescription drugs, that, through and through, that bill would be bipartisan. I would hope, obviously, it can relate to some of the funding issues and recoup some of the investment our taxpayers have made through the direct funding through the NIH or IRS piece of the Code where we pay and subsidize pharmaceutical companies to do what is in their business plan, develop drugs.

I yield additional time to my good colleague from Minnesota.

Mr. GUTKNECHT. I appreciate the gentleman mentioning the bipartisan nature of this, because we did a special order last week, and we had Democrats and Republicans. We had some of the most conservative Republicans, and what I think most of us would agree are some of the most liberal Democrats, agreeing on this issue, and that is Americans should not have to pay

the world's highest prices when we are the world's best customers and when we spend more for the development of those drugs.

I am also the vice chairman of the Committee on Science. Just to share with my fellow colleagues how much we spend on research, and we should be proud of this, this year in this budget we will spend almost $29 billion on various kinds of basic research. In fact, we represent as Americans less than 6 percent of the world's population; we represent more than half of all of the basic research done in the world. I am proud of that. But we should not have to pay for these drugs a second and a third time when we helped develop them.

We are not asking for special breaks. All we are asking for is fairness. Reimportation or importation is not a perfect answer, but we do know that markets are more powerful than armies, and ultimately markets, whether it is the market for grain or the market for diamonds, has a tendency to level prices all over the world.

Let me just mention one other thing, and I mentioned this in a 5-minute special order I did earlier. This is the June 9 issue of U.S. News and World Report. In it there is a true American patriot. Her name is Kate Stahl. She is 84-years-old and she describes herself as a drug runner.

The tragedy is that the American government treats her as a common criminal because she helps her fellow seniors through the Senior Federation of Minnesota acquire drugs from other countries at affordable prices. In the article she says, and this is why I think she is a patriot, ''I would like nothing better than to be thrown in jail.'' That is a patriot. She is willing to do that for her fellow seniors so that they can get affordable prices on drugs.

Mr. EMANUEL. First of all, I thank the gentleman for organizing this and thank you for introducing your legislation. I think this is the right approach.

I think, again, whether it is the area of generics coming to market and updating our patent laws, whether it is the tariffs or limitations we put on importation or access to these drugs, the same drugs we see on the shelves in our pharmacies, that the American consumer has access to them, each of these, at least on the generic and reimportation, are bipartisan issues.

I think that this is the right approach, not only because it is bipartisan and it reflects our values and reflects a common set of values that we can come around, but, most important, is that in dealing with the issue of a prescription drug, the truth is, all these drug plans have some limitations. People will not be covered. So the question is, how do you squeeze the most out of that dollar? It may be $400 billion over 10 years. The final product may be $450 billion.

The question, though, we have to ask ourselves is, can we get more out of that? Can we get more people covered? Can more people get a plan, so their deductible is not as high as it is? And the only way to do that is to make sure that a prescription drug plan as it relates to Medicare, as it relates to the cost of prescription drugs in the dime stores and drugstores and pharmacies across the country, can we reduce the prices? We can do that if we would bring the free market approach to the pharmaceutical industry.

So I applaud this. I am very pleased to be a bipartisan supporter and original cosponsor of the gentleman's legislation. I am on the generic drug legislation.

I think that approach comes together, not just because we are Democrats and Republicans, we come together on a common set of values. We approach this from the basis we may need more money for a prescription drug benefit plan, but we are going to make sure this $450 billion over 10 years, we get the biggest bang for the buck, and that this game that has been going on, and they have been gaming the system, is going to come to an end.

We are not going to allow this to happen. We are not going to allow you to have frivolous lawsuits that keep patents on another 30 months. I want frivolous lawsuits to end. We are going to have them end. It is specifically how pharmaceuticals have been treating generic drugs and preventing them from coming to market.

We are not going to allow the pharmaceutical companies to keep up the game and not allow us to import the same drugs that overseas are at close to 30 percent to 300 percent cheaper than we pay here. And if you did that, you would be on your first step of controlling health care inflation that has been running at close to 20 to 25 percent, which is just suffocating our small and large businesses, who are seeing their insurance policies just go right through the roof.

The second item, obviously, and we may have a different approach to this, but the second item would be to insure the uninsured in this country. If you did that, and I also note when it relates to the working uninsured in this country, the only issue in which the Chamber of Commerce and the AFL-CIO agree on on health care, and they are both running campaigns, is we have got to insure the working uninsured.

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They are showing up in emergency rooms, they are driving up the cost of insurance policies, and the hospitals pass that on to insurance policies, insurance policies pass it on to businesses, and businesses now pass it on to employees. And those two factors, controlling the cost of drugs and insuring the uninsured, would literally be taking the steam out of the pipe as it relates to health care inflation. If we do that, we will see immediately the health care tax alleviation for our middle-class and working-class families all across the country.

I applaud the bipartisanship and look forward to working with the gentleman on this. Hopefully, we will get an opportunity to offer an amendment to the prescription drug bill when it is down here on the floor, because it is going to be essential in making sure that whatever dollars we spend of the taxpayers, that we stretch those dollars to the greatest possibility. I think the American people, if they knew that we had the opportunity to offer an amendment bringing free market principles, competition to this debate, to make sure that they got a return on their dollar of investment, to make sure that the pharmaceutical companies could not prevent other choices from coming to market, be they from overseas or in the generic area, they would applaud our work, Democrats and Republicans and Independents alike; people north, south, east and west would applaud us, because we would be coming around a common set of values that we all can agree on. So there will be places that we disagree, but on these there is bipartisanship. So that would be my hope. I think we will be successful if we can come together in this area, work together, make sure the principles of the free market and our values are reflected in what we pass.

So again, I want to applaud the gentleman for introducing this, bringing this to my attention, although I have talked to many people about it but, most importantly, being open to working together across party lines so we can represent the people we came here to, not only vote on their behalf, but to give voice to their values.

Mr. GUTKNECHT. Mr. Speaker, just one last comment, and I thank the gentleman for this Special Order tonight. As we mentioned earlier, this is not a matter of right versus left, this is right versus wrong. It is simply wrong to make American consumers pay the world's highest prices for drugs which largely the American taxpayers helped develop in the first place.

The gentleman mentioned one other thing, and I think it is a very serious concern. Some people are saying, well, through these plans in Medicare, we will squeeze down the prices, but if we do not do something to bring market forces to bear on the overall cost of prescription drugs, what may well happen is the price for these prescription drugs will go up even more for those 41 million Americans that are currently uninsured. They are the ones who have to pay cash, they are the ones whose kids get sick with tonsillitis or ear infections or conjunctivitis, and they need those prescriptions as well.

So this is not just about helping to keep down the price of prescription drugs for seniors; it is for all consumers and particularly for those uninsured or partially insured Americans who pay the world's highest prices. Hopefully, on a bipartisan basis, we will ultimately begin to get at those issues, whether it is the whole issue of importation of prescription drugs or bringing the generics to market faster

so that Americans have those drugs at affordable prices.

But again, this is not a partisan issue as far as I am concerned. I look forward to working with the gentleman and other Members on the other side of the aisle because ultimately we owe it to every American to make certain that we get fair prices for the drugs that they desperately need.

Mr. Speaker, I thank the gentleman from Illinois (Mr. EMANUEL) for this Special Order.

THE ILL EFFECTS OF ASBESTOS LAWSUITS ON OUR ECONOMY

The SPEAKER pro tempore (Mr. FRANKS of Arizona). Under the Speaker's announced policy of January 7, 2003, the gentleman from Illinois (Mr. KIRK) is recognized for 60 minutes as the designee of the majority leader.

Mr. KIRK. Mr. Speaker, across our country, the state of our economy is the number one issue on people's minds. America's economy is reeling from a 3-year-old recession and the shock of September 11 and war jitters from Iraq. This Congress has acted to restore our homeland and national security. We have passed corporate reforms to stop the dot-com abuses that sparked our recession. Our Armed Forces have won a great battle in Iraq. But now, the latest news from our markets is somewhat encouraging. We bottomed out in the Dow Jones industrials at under 7,500, and we are now back over 9,000. But still, the economy is sluggish. Why? Are there other issues weighing against new savings and investments?

There are. There is one key issue that is casting a very dark cloud on America's economy, on our employment and, especially, our retirement savings. What is that issue? Lawsuits. Lawsuits. But not just any lawsuit. These are asbestos lawsuits.

Tonight, over 900 stocks that form the heart of our retirement IRAs are depressed because of asbestos litigation. We have already bankrupted manufacturers of asbestos long ago. People poisoned by these companies collect only 5 cents on the dollar from the empty shelf of what once were large employers.

In 1983, only 300 companies faced asbestos lawsuits from about 20,000 plaintiffs. Despite asbestos largely leaving our economy, we now see 750,000 plaintiffs suing over 8,000 employers. Sixty major employers have already closed their doors, and a third of those employers gave pink slips to their workers in just the last 2 years. With 8,000 plaintiffs crowding into our courts, no one gets justice. People who are truly sick die waiting for their day in court and the health care that they need. Others who file a case wait in line, hoping to win the asbestos lottery for them and their personal injury lawyers.

Our system of bankrupting employers and depressing the IRA savings of America could make some sense if those who are sick are compensated, but the data shows different. From 1980 to 2002, employers and insurers paid $70 billion in claims. Plaintiffs received only $28 billion out of the $70 billion paid. So where did the other $42 billion go? As the chart next to me shows, it went to personal injury lawyers and court costs. Not a penny of those funds went for hospital costs or to pay surviving relatives. Sixty percent of funds under the current system go to lawyers and court costs.

Clearly, American justice can do better. We say, ''Justice delayed is justice denied.'' But justice is delayed here. We say, ''We built a system to make the injured whole,'' but the injured are not made whole here. Supreme Court Justices have decried our wayward system of asbestos justice. Justice Ruth Bader Ginsberg called on Congress to act. Justice David Souter said the system was an ''elephantine mass'' which defies customary judicial administration, and calls for national legislation.

What happens if we do nothing? What happens if we leave well enough alone? According to the National Economic Research Associates and the Rand Institute, asbestos litigation costs 60,000 Americans their livelihoods. Without reform, Rand estimates 423,000 Americans will lose their jobs because of the expanding cloud of asbestos litigation. Never in the history of our economy have so many lost their incomes to so few who received so little for the benefit.

Asbestos litigation reform may be the most important remaining economic reform legislation for this Congress to pass. Reform means saving half a million American jobs. Reform means lifting the value of millions of IRAs. Reform means paying victims and their families with the lion's share of awards, not personal injury lawyers. And reform is needed now. Congress has several proposals before it.

Earlier this year, I introduced H.R. 1114, the Asbestos Compensation Act of 2003, with 40 cosponsors, the largest number of asbestos reform cosponsors for any legislation in this Congress. My colleague, the gentleman from Utah (Mr. CANNON), introduced H.R. 1285, the Asbestos Compensation Fair Act. Our Democratic colleague, the gentleman from California (Mr. DOOLEY), introduced H.R. 1737. And in the Senate, Senator NICKLES introduced S. 413. All eyes in Washington on this issue have now focused on Senator HATCH's bill, S. 1125, the Fairness in Asbestos Injury Resolution Act, or FAIR Act. It is scheduled for a markup in the Senate in 48 hours.

This is the most important economic legislation for this Congress. And what do all of these bills do? They are based around core principles of American justice. One: that we seek to compensate the injured; two, that we bring about a rapid resolution of disputes; three, that decisions become final; and, four, that we administer justice uniformly. Our current system fails to meet any of these time-honored values.

The legislation Congress is considering would remove the myriad of cases from various courts in States to a new Federal court or office that would develop an expertise and uniform administration of 8,000 lawsuits. Why do this? Let me give some examples.

Robert York received an asbestos award from his State court. He was asymptomatic with lung scarring, and he got $1,200. He had to pay $600 of it to his lawyer. Bill Sullivan was exposed to asbestos, with no symptoms, still got $350,000. Keith Ronnfeldt was exposed to asbestos and he got just $2,500, but, of course, had to pay $1,200 to his lawyer. Mrs. Keith Ronnfeldt was exposed, but she got just $750 and, of course, had to pay $375 to her lawyer. Ron Huber got asbestos-related illness and received an award of $14,000, but it is still pending appeal, and Ronald has not been paid. Meanwhile, James Curry, with asbestosis, won an award of $25 million; but once again, under appeal, he has not been paid.

This is not justice. Victims are left to die, and plaintiffs with no symptoms are litigants in a system that only the lawyers win.

We stand for a different principle. The major themes of reforms are to form a new Federal office or court to swiftly and surely compensate victims. But who pays?

Under our reforms, current defendants, employers, and insurers pay, with some leeway for other defendants to be added. Without reform, Rand estimates, plaintiffs, uninsured and insured alike, will be awarded $200 billion, bankrupting dozens of employers and throwing 400,000 Americans out of work.

But remember, most award money goes to lawyers and court costs, not to plaintiffs. That means without reforms, $200 billion will be awarded, but only $80 billion will go to victims and uninsured plaintiffs.

We argue for a better system. Rather than have only $80 billion paid to victims, we, for example, under Senator HATCH's reforms, would pay over $100 billion, 20 percent more, to the victims. Who loses? Under our reforms, only the lawyers would lose, but the victims would win; and so would the American economy.

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So would the American economy.

Without so many asbestos lawsuits filed by thousands on the chance of victory, we would remove a cloud of litigation from our economy's future. We would also follow another key principle, those injured should be the ones compensated best and first.

Under the current system, plaintiffs with the fastest lawyer, suing the richest defendant, wins. The sickest plaintiff, suing a poor or bankrupt defendant, loses. That is wrong. Our reforms care for the sickest most, regardless of financial capacity of the defendant.